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UPDATED REPORT: INVOLUNTARY OUTPATIENT MENTAL HEALTH TREATMENT LAWS

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You asked for an update of OLR Report 2011-R-0438, which described involuntary outpatient mental health treatment laws in other states. You want to know how often the states with such laws have invoked them. Finally, you requested information on recent legislative changes to New York's outpatient commitment law.

SUMMARY

Involuntary outpatient treatment (also called "assisted outpatient treatment" (AOT)) is court-ordered, community-based treatment for people with untreated severe mental illness, such as bipolar disorder or schizophrenia, who meet strict legal criteria. Generally, these individuals are too ill to recognize they need medical care and have a history of medication and treatment noncompliance. The goal of AOT is to provide treatment to these individuals before they require psychiatric hospitalization. Proponents of AOT laws believe they reduce psychiatric hospital admissions, homelessness, and violence and improve treatment compliance. Those opposed feel such laws remove an individual's civil right to choose where and how to receive treatment.

According to the Treatment Advocacy Center, 44 states and the District of Columbia allow courts to order involuntary outpatient treatment for people with severe untreated mental illness. Connecticut is one of six states (also Maryland, Massachusetts, New Mexico, Nevada,

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and Tennessee) that do not have such a law. New Jersey's AOT law took effect in August of 2010, but its implementation was delayed by Governor Christie due to inadequate funding for treatment. In 2012, the New Jersey legislature appropriated approximately $2 million to begin its implementation.

States vary somewhat in terms of eligibility requirements, processes, and who can apply to the court to admit an individual to AOT. For example, some states such as Florida, California, and New York limit AOT to adults, whereas other states such as Georgia, Maine, and North Carolina also allow minors to receive such treatment. Some states require an individual to be involuntarily hospitalized at the time of the court application for AOT, while others allow an application to be initiated when an individual still lives in the community.

We have summarized four states' AOT laws: Maine, New Hampshire, New Jersey, and New York, including the most recent changes to New York law in response to the Newtown, Connecticut school shootings and an evaluation of the state's program. Additionally, we have provided statistical information, where available, on how frequently these four states actually invoke their AOT laws. A web link to a chart with all 50 states' involuntary inpatient hospitalization and outpatient treatment laws is provided for your additional information.

New York amended its AOT law earlier this month. Some of the changes include (1) doubling the period of court-ordered outpatient treatment for an initial court commitment and (2) ensuring continuity of care for those patients who move from one part of the state to another.

MAINE

Law

Maine law authorizes court-ordered outpatient treatment through a "progressive treatment program" (PTP). The superintendent or chief administrative officer of a psychiatric hospital, the commissioner of the Department of Health and Human Services (DHHS), or the director of an "Assertive Community Treatment" (ACT) team may apply to the District Court to commit an individual to the PTP. (An ACT team director may apply only if the team existed as of April 14, 2010 and complies with nationally recognized standards DHHS identifies.)

To be eligible for involuntary outpatient treatment in Maine, an individual must:

1. have a severe and persistent mental illness;

2. pose a likelihood of serious harm;

3. have an individualized treatment plan and community resources available to support the plan; and

4. be unlikely to voluntarily follow the treatment plan.

In addition, the court must find that court-ordered compliance will (1) help protect the individual from interruptions in treatment, relapses, or mental health deterioration and (2) enable him or her to survive more safely in a community setting without posing a likelihood of serious harm.

PTP services are provided based on an individualized treatment plan. The court commits the individual to the care and supervision of an ACT team or other outpatient facility. An ACT team is on duty 24 hours per day, seven days per week and includes at least a psychiatrist, registered nurse, rehabilitation counselor or employment specialist, peer recovery specialist, and substance abuse counselor.

The court commits an individual to the PTP for an initial period of up to 12 months and may grant an unlimited number of 12 month extensions. If an individual fails to comply with the PTP, the court may order an emergency authorization to hospitalize the patient for evaluation and treatment (34B MRSA § 3873-A et seq).

Implementation

Maine has two state hospitals that accept PTP referrals: Riverview Psychiatric Center and Dorothea Dix Psychiatric Center, both of which began accepting PTP referrals in 2007. According to DHHS, from January 2007 through December 2011, the following enrollment statistics for the PTP program were reported at Riverview:

- 21 commitments involving 15 individuals (one individual was admitted three times and two were admitted twice)

- Of the 21 commitments, nine fully completed the PTP.

- As of December 2011, there were four clients enrolled in the program.

At Dorothea Dix, the following PTP enrollment statistics were reported for the same period:

- 45 commitments involving 42 individuals (three clients had two commitments)

- Of the 45 commitments, 27 fully completed PTP.

- As of December 2011, there were five clients enrolled in PTP.

The most recent statistics provided by Riverview's superintendent show that Riverview has had 25 and Dorothea Dix 48 total PTP commitments ranging in duration from six to 12 months since 2007. The ACT team at Riverview is employed by the state, while the state contracts for the ACT team at Dorothea Dix.

NEW HAMPSHIRE

Law

New Hampshire law allows any "responsible person" (the law does not define this term) to petition the court to commit an individual to involuntary outpatient treatment. An individual is eligible for such treatment if he or she has a mental illness that creates a potentially serious likelihood of danger to him- or herself or others as evidenced by either:

1. self-infliction of serious bodily injury, attempted suicide, or serious self-injury in the last 40 days which is likely to reoccur without treatment;

2. threatened self-infliction of serious bodily injury in the last 40 days and likely to attempt to inflict serious self-injury without treatment; or

3. lack of capacity to care for his or her own welfare and a likelihood of death, serious bodily injury, or serious debilitation.

In addition, an individual must have:

1. severe mental disability for at least one year and an involuntary hospital admission within the last two years;

2. refused necessary treatment and a psychiatrist has determined there is a substantial probability that this refusal will lead to death, serious bodily injury, or serious debilitation;

3. threatened, attempted, or committed violent acts in the last 40 days; and

4. no guardian.

If an individual meets these criteria, he or she is involuntarily admitted to the state's psychiatric hospital, New Hampshire Hospital (called an Involuntary Emergency Admission (IEA)). Within three days of admission, a district court judge must hold a probable cause hearing and can commit the individual to outpatient treatment at a local community mental health center (CMHC) as part of a conditional discharge. The court sets the length of the commitment and treatment conditions as developed by the CMHC and the patient. The patient is then immediately discharged from the hospital and begins outpatient treatment.

If the individual complies with the treatment plan, he or she is released at the end of the outpatient commitment term. If the individual is noncompliant, the CMHC must schedule a probate court hearing to review the case and request the individual's rehospitalization. (New Hampshire Revised Statutes Annotated §§ 135-C:27 to 135-C:61).

Implementation

An official at New Hampshire Hospital reported that the hospital discharges about 1,800 patients each year, and that approximately 30% of those are conditional discharges, i.e., the patient must undergo outpatient treatment. The average length of the court-ordered treatment is between one-and-a-half and two years.

NEW JERSEY

Law

New Jersey's involuntary outpatient commitment (IOC) law took effect in August 2010 (P.L. 2009, Chapter 112). It allows a short- or long-term care psychiatric facility, psychiatric hospital, screening service, or outpatient treatment provider to apply to the court to commit an individual to involuntary outpatient treatment.

Individuals are eligible for outpatient commitment if they (1) have a mental illness that causes them to be a danger to self, others, or property and (2) are noncompliant with needed treatment. The law defines someone as being a danger to self if he or she is unable to satisfy the need for nourishment, essential medical care, or shelter without assistance and that substantial bodily injury, physical harm, or death is probable in the near future. This determination must also take into account the individual's history, recent behavior, and any recent act, threat, or serious psychiatric deterioration.

The law directed the commissioner of the Department of Human Services (DHS) to phase in its implementation over a three-year period by selecting seven counties per year to implement it. For each county selected, the department must contract with a community service provider as the designated "outpatient treatment provider" for that county. (New Jersey Statutes Annotated §§ 30:4-27.2).

Implementation

Because the legislature did not appropriate additional funds to DHS for FY 11, Governor Christie delayed its implementation. For FY 2012, the legislature appropriated approximately $2 million, and DHS announced that it was launching the IOC in May 2012. Roger Borichewski from the New Jersey Office of Prevention, Early Intervention and Community Services, Division of Mental Health and Addiction Services, reported that this funding allowed the department to implement only six IOC programs.

IOC is modeled after the existing statute for screening inpatient commitment services. New Jersey contracted with new vendors to provide IOC screening when a candidate arrives at the emergency room. Patients are assigned to IOC in the same way that an inpatient is in New Jersey, through the probate court. The judge may order a person who is (1) found not to be an imminent danger to him- or herself or others and (2) whose best prognosis is that of a person with the potential for danger in the foreseeable future to participate in an IOC. Patients may also be released from inpatient into outpatient programs.

Borichewski noted that since the program's implementation, most outpatient commitments have been inpatient conversion orders, in which the patient is already detained and the court, upon the recommendation of the appropriate healthcare experts, releases the person in custody to outpatient treatment. A clinician determines where the person is held while the court is making this decision. Technically, someone who comes in after being admitted can be released back to the community until his or her case is heard and a determination made.

A judge can order a class of medication (e.g., antipsychotics) for a specific person undergoing inpatient or outpatient commitment, but may not order a specific prescription. When a patient does not comply with his or her treatment order, the IOC program notifies the judge, who decides if there is a breach. The judge also orders a screening center to assess the person. If the patient is an imminent danger, he or she is committed as an inpatient. If not, the patient's treatment order is adjusted appropriately to reflect his or her needs.

The New Jersey IOC statute requires a program evaluation. New Jersey has contracted with Rutgers University to track data concerning how many people use IOC and for how long. Because IOC was recently implemented, data is not yet available.

NEW YORK

Kendra's Law

In 1999, the legislature enacted a law allowing courts to order involuntary outpatient treatment for certain individuals with mental illness who, when considering their treatment history and current circumstances, are unlikely to safely survive in the community without supervision. The law is commonly referred to as "Kendra's Law," after Kendra Webdale, a young woman who died in 1999 after being pushed in front of a New York City subway train by a person with untreated schizophrenia.

An individual can only be placed in AOT by an order of the supreme or county court where that individual lives. People who may apply to the court for such an order include:

1. the individual's adult roommate, parent, spouse, adult child, or adult sibling;

2. the director of a psychiatric hospital where the individual is hospitalized;

3. the director of a nonprofit or public agency or home that provides mental health services to the individual;

4. a treating or supervising licensed psychiatrist, psychologist, or social worker;

5. the director of community or social services in the town or city where the person lives; or

6. a supervising parole or probation officer.

The law prohibits an individual from being placed in an AOT unless the court finds by clear and convincing evidence that the individual:

1. is at least 18 years old;

2. has a mental illness;

3. based on a clinical determination, is unlikely to safely survive in the community without supervision;

4. has a history of treatment noncompliance that has (a) at least twice in the last three years been a significant factor in his or her being hospitalized or receiving services in a correctional facility or (b) resulted in one or more acts of serious violence or threats or attempts of such acts in the last four years;

5. is unlikely to voluntarily participate in the outpatient treatment because of his or her mental illness;

6. is in need of AOT to prevent a relapse or deterioration that would likely result in serious harm to him- or herself or others; and

7. is likely to benefit from AOT.

A court cannot issue an AOT order unless it finds that AOT is the least restrictive alternative available to that person.

If the court determines an individual meets the criteria for AOT, it issues an order to the person who oversees the county or local mental health program. The order is based on a written treatment plan the examining physician submits. The order may involuntarily compel medication, therapy, rehabilitative services and blood and urine testing. An initial order is effective for up to one year and can be extended for

periods of up to one year. The law also establishes a procedure for hospital evaluation in cases where the individual fails to comply with the ordered treatment and may pose a risk of harm.

The law requires the Office of Mental Health to designate "program coordinators" responsible for monitoring and overseeing AOT programs. County directors of community services must operate AOT programs, either individually or jointly with other counties. The mental health commissioner must approve all AOT programs.

An individual who is noncompliant with the AOT order may be held for up to 72 hours in a psychiatric hospital, during which he or she is evaluated to determine whether involuntary hospitalization is required (New York Mental Hygeine Law § 9.60).

2013 Changes

Earlier this month, the New York legislature passed a law concerning firearm regulation and mental health in response to the Newtown, Connecticut school shootings. The new law made several AOT-related changes to "Kendra's Law":

- The initial period of court-ordered outpatient treatment was extended from six months to one year.

- Before an AOT order expires, county directors of community services must evaluate the need for ongoing AOT. If a director determines that the outpatient continues to meet the criteria for AOT, he or she may petition the court to order continued AOT.

- When a director has reason to believe that an outpatient has or will change his or her county of residence while an AOT order is in effect, he or she must notify the community services director in the outpatient's new county of residence. The director in the outpatient's new county of residence must provide outpatient care services.

- The Kendra's Law sunset date was extended from June 30, 2015 until June 30, 2017.

Implementation

According to OMH, 10,923 AOT petitions were filed between November 1999 and January 2013, of which 10,618 were granted. The median length of time individuals spent in AOT was 12-18 months. And over

18,000 individuals have been screened for AOT. A total of 6,492 court orders have been renewed (63%). Currently, 1,814 people are active under an AOT court order, with a total of 2,874 people active during the past 12 months.

Evaluation

A 2009 AOT program evaluation noted that AOT recipients represent a small percentage of the total number of adults who receive OMH services. For example, in 2005, of the 138,602 OMH adult service recipients with severe mental illness, only 2,420 (1.7%) received AOT treatment. Despite this relatively small number, the evaluation found that AOT recipients received disproportionate attention because of their serious needs, high care costs, and the public's concern about the target population for Kendra's Law.

The evaluators also noted that some counties have an AOT program and never use it and some have no AOT program at all; these are often smaller counties or those that use a different program to coordinate services for high-need patients. All counties receive AOT program funding from the state; those that do not use an AOT program may use that funding to serve high-risk patients in other ways.

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